

Dr. Angela Lee LLND
22 Richmond Street, Suite 201 Richmond Hill, ON L4C 3Y1
(t) 905 237 7031 (f) 905 237 7034
lymend.com

INFORMED CONSENT FORM

Naturopathic medicine is the treatment and prevention of diseases. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual.

Your Naturopathic Doctor will take a thorough case history, perform a physical examination, and may obtain a blood and urine sample (as part of the health screening process). If your case requires, the physical may include more specific examinations such as gynecological, rectal, prostate or genital exams. If your case requires further laboratory blood tests, your Naturopathic Doctor may refer you to a Medical Doctor or an appropriate lab where additional fees may or may not apply.

It is my responsibility to immediately inform my Naturopathic Doctor of:

Any disease process or health complication that you are suffering from
If you are on any medication or over the counter drugs
If you are or suspect pregnancy or actively attempting to become pregnant
Currently breastfeeding

Naturopathic doctors are trained and may use the following modalities: Intravenous Vitamin Therapy, Biopuncture, injectable vitamins, diet and nutritional counselling, acupuncture, botanical medicine, physical modalities, and lifestyle counselling.

I further understand that there are some slight health risks to treatment by Naturopathic Medicine. These include, but are not limited to;

Aggravation of pre-existing symptoms
Allergic reactions to supplements or herbs
Pain, bruising, fainting or injury from venipuncture, acupuncture or cupping

I have also been informed and understand the fee schedule and understand the cancellation policy of providing the clinic a minimum 48 hours notice to rebook or cancel my appointment, otherwise an amount of 50% of the consultation fee will be charged.

Therefore, I hereby give my consent as outlined by the Ontario regulatory board. My consent is for the naturopathic treatments offered or recommended to me by Dr Angela Lee LLND. I intend this consent to apply to all my present and future naturopathic care.

I understand:

- **That Dr. Angela Lee LLND do not guarantee treatment results.**
- **That Dr. Angela Lee LLND will explain to me the exact nature of any treatment provided and will answer any questions I may have to the best of their ability.**
- **That I am responsible to pay the fees for naturopathic services and any products from the dispensary at the time of the visitation. I have reviewed the fee schedule and cancellation policy as outlined in the Patient Information package.**
- **I am free to withdraw my consent and to discontinue treatment at any time.**

PLEASE READ BEFORE SIGNING

Patient Name

Signature of Patient/Guardian

Patient Signature

Witness Signature

Date

Witness Name